DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Pharmacies
All Prescribers
Managed Care Plans
Nursing Home Administrators

Memorandum No: 05-01 MAA
Issued: January 3, 2004

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

For More Information, call:
1-800-562-6188

Subject: Prescription Drug Program: Expedited Prior Authorization Updates

Effective the week of February 7, 2005, **and after**, the Medical Assistance Administration (MAA) will implement the changes to expedited prior authorization codes and criteria for MAA's Prescription Drug Program outlined in this memorandum.

Changes to Expedited Prior Authorization Codes and Criteria

Drug	Code	Criteria
Enbrel® *(etanercept)*	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.

Billing Instructions Replacement Pages

Attached are replacement pages H.9-H.10 for MAA's current *Prescription Drug Program Billing Instructions*.

How can I get MAA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Drug	Code	Criteria
Duragesic® *(fentanyl)*	040	Diagnosis of cancer-related pain.
Enbrel® *(etanercept)*	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
Fazaclo® *(clozapine)*	012	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 18 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above; and d) Must have tried and failed generic clozapine.
Focalin® *(dexmethylphenidate HCl)*		See criteria for Concerta®.

Drug	Code	Criteria
Geodon® *(ziprasidone HCl)*	046	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
		Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.
Glycolax Powder® *(polyethylene glycol)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Humira Injection® *(adalimumab)*	028	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every two weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
Infergen® *(interferon alphcon-1)*	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
Intron A® *(interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminate (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.

Drug	Code	Criteria
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
Kadian® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Kineret Injection® *(anakinra)*	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
Kytril® *(granisetron HCl)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Lamisil® *(terbinafine HCl)*		Treatment of onychomycosis for up to 12 months per nail is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy; or
	045	Fingernail involvement with or without chronic paronychia.
Levorphanol	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Lotrel® *(amlodipine besylate/benazepril)*	038	Treatment of hypertension as a second line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
Marinol® *(dronabinol)*	035	Diagnosis of cachexia associated with AIDS
	036	Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.
Metadate CD® *(methylphenidate HCl)*		See criteria for Concerta®.
Miralax® *(polyethylene glycol)*		See criteria for Glycolax Powder®
Naltrexone		See criteria for ReVia®.
Nephrocaps®	096	Treatment of patients with renal disease.
Nephro-FER® *(ferrous fumarate/ folic acid)* **Nephro-Vite®** *Vitamin B comp W-C)* **Nephro-Vite RX®** *(folic acid/vitamin B comp W-C)* **Nephro-Vite+FE®** *(fe fumarate/FA/ vitamin B comp W-C)* **Nephron FA®** *(fe fumarate/doss/ FA/B comp & C)*		